THE HONORABLE BENJAMIN H. SETTLE

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON
AT TACOMA

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|---|---|
| LINDA STILLWELL and RICHARD STILLWELL, husband and wife and marital community thereof,,<br><br>Plaintiffs,<br><br>v.<br><br>MULTICARE HEALTH SYSTEM, a Washington Corporation, and SHARON CHANCE and JOHN DOE CHANCE and the marital community thereof,,<br><br>Defendants. | No. 3:11-cv-05117-BHS<br><br>DEFENDANTS' FIRST SET OF INTERROGATORIES AND REQUESTS FOR PRODUCTION OF DOCUMENTS TO PLAINTIFFS |

TO: Linda Stillwell and Richard Stillwell, Plaintiffs

AND TO: Michael J. Davis, Attorney for Plaintiffs

Pursuant to Rules 26, 33, and 34 of the Federal Rules of Civil Procedure, Defendants MultiCare Health System (hereinafter "MHS"), Sharon Chance, and "John Doe" Chance submit the following discovery requests to you, to be answered in writing and under oath, within thirty (30) days after the date of service hereof.

You are also requested to produce identified documents for inspection and copying at the offices of Stoel Rives LLP, 600 University Street, Suite 3600, Seattle, Washington, or at such other time and place as shall be mutually agreed upon by counsel. Inspection and copying will



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be conducted by Defendants' attorneys and their agents and will continue from time to time and from day to day until completed.

## GENERAL INSTRUCTIONS

In responding to these requests for production of documents, furnish such information as is available to you, regardless of whether this information is obtained directly by you, through your agents or representatives, or anyone acting on your behalf or on their behalf. If you cannot respond to these requests for production in full, respond to the extent possible, specify the reasons for your inability to respond to the remainder, and state whatever information or knowledge you have concerning the unanswered portion.

Please note that certain of these discovery requests are continuing in nature. If you obtain, directly or indirectly, additional information as defined by Federal Rule of Civil Procedure 26(e) between the time your answers and responses are served and the time of trial, you must promptly bring such information to Defendants' attention through supplemental responses. If any such information or documentation is not furnished, Defendants may move to exclude from evidence such information or documentation, or for other appropriate relief.

If your response to any request for production is "N/A" or "not applicable," describe in detail your reasons for making such a reply.

Documents produced in response to Defendants' requests for production of documents pursuant to Federal Rule of Civil Procedure 34 should be expressly identified by reference to the request for production to which they pertain.

## PRIVILEGE

If you claim any privilege with respect to any information called for by any request for production or any part thereof, identify the type of privilege which is claimed, state the basis for the claim of privilege, identify the communication, document or other item as to which the privilege is claimed, and state the subject matter thereof. If you claim any such privilege, you



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should nevertheless answer or respond to the interrogatory or request for production to the extent that it calls for information as to which you do not claim a privilege.

**DEFINITIONS**

The following definitions govern these requests, unless conclusively negated by the context of the request.

1. The word "person" refers to and includes any natural person, individual, firm, association, partnership, joint venture, corporation, LLC, company, estate, trust, receiver, syndicate, proprietorship, municipal or other governmental corporation or agency, including groups and combinations of the same acting as a unit.

2. The term "Plaintiff Linda Stillwell" refers in every instance to Plaintiff Linda Stillwell and any or all persons and entities acting for Ms. Stillwell without limitation, attorneys, employees, officers, agents, directors, independent contractors, successors, predecessors, parents, subsidiaries, affiliates, and other persons and entities under the control of any of them.

3. The term "Plaintiffs" refers in every instance to Plaintiffs Linda Stillwell and Richard Stillwell and any or all persons and entities acting for Mr. and Ms. Stillwell without limitation, attorneys, employees, officers, agents, directors, independent contractors, successors, predecessors, parents, subsidiaries, affiliates, and other persons and entities under the control of any of them.

4. The term "MHS" refers in every instance to Defendant MultiCare Health System.

5. The terms "you" and "your" refers in every instance to Plaintiffs as defined in definitions number 2 and 3, above, and all persons and entities acting for Plaintiffs including, without limitation, attorneys, employees, officers, agents, independent contractors, and other persons and entities under the control of Plaintiffs.

6. The term "document" is used in the broadest sense permissible under the Federal Rules of Civil Procedure and is meant to include any medium upon which intelligence or information can be recorded or retrieved and as used herein, refers to and includes, without



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limitation, the original and each non-identical copy (whether non-identical because of alteration, attachments, blanks, comments, notes, underlining or otherwise) of any "document," however produced or reproduced, which "document" is in your possession, custody, or control or the possession, custody, or control of your agent, servant, employee, including, without limitation, the following: whether in electronic or hard copy, agreements, contracts, proposals, bids, memoranda, orders, letters, journals, notes, telexes, telegrams, billings receipts, invoices, drawings, plans, rough notes, log books, diaries, reports, surveys, messages, summaries, electronic mail or messages, or any other writings or tangible things on which any handwriting, typing, printing, photostatic, or other form of communication is or are recorded or reproduced, as well as all notations on the foregoing, including originals, all file copies, and all other copies of the foregoing, together with all drafts on notes (whether typed, handwritten, or otherwise) made or prepared in connection with such documents, whether used or not. "Document" shall also include, without limitation, any record of all or any portions of any discussion, communication, agreement, conversation, interview, meeting, conference, conclusion, fact, impression, occurrence, opinion, report or other similar matter, and shall include, without limitation, all correspondence, papers, cablegrams, mailgrams, telegrams, notes, memoranda, summaries, abstracts, worksheets, books, manuals, publications, engineering reports and notebooks, schematics, engineering drawings, software source code listings, plats, charts, plans, databases, diagrams, sketches or drawings, photographs, reports and/or summaries of investigations and/or surveys, opinions and reports of appraisers or consultants, projections, corporate records, minutes of board of directors or committee meetings, desk calendars, appointment books, diaries, diary entries, emails, voicemails and notes, newspapers, magazines, or periodical articles, and other record of any kind. "Document" shall further include all aural or visual record or representations, (including without limitation photographs, microfiche, microfilm, videotape, sound recordings, and motion pictures) and computer, electronic, mechanical or electric records



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or representations of any kind (including without limitation, tapes, cassettes, discs, recordings, programs, databases, archival records, etc.).

7. "Electronically stored information" includes, without limitation, email, texting, social media (Twitter, Facebook, MySpace and other social media), voicemail, documents, spreadsheets, calendars, and any other information existing in any electronic format (e.g., Word, Excel, Outlook, .pdf, HTML, .tif, .jpeg, .wav).

8. The term "describe" and/or "describe in full detail" means to fully, faithfully, and accurately set forth every fact and circumstance, including omissions, which in any way relates to, refer to, reflect, comprise or bear upon a matter of inquiry.

9. The term "relating to," "relates to" and "related to" means, without limitation, comprising, concerning, containing, embodying, referring to, alluding to, responding to, about, regarding, explaining, discussing, showing, describing, studying, reflecting, analyzing or constituting. A communication or document "relating" to any given subject means any communication or document that constitutes, contains, embodies, reflects, identifies, states, refers to, deals with, or is in any way pertinent to that subject, including, without limitation, documents concerning the preparation of other documents.

10. The terms "identify" and "identification" when used in reference to an individual person means to state his or her full name, present or last known residence and business telephone numbers, and present or last known residence and business addresses, if known, and his or her present or last known title, position and business affiliation.

11. The terms "identify" and "identification" when used in reference to a person other than a natural person mean to state the full and official name of the business entity, its principal place of business, and the main telephone number of such business entity.

12. The terms "identify" and "identification" when used in reference to a document mean to state its date, type (e.g., memo, telecopy, email), and its authors, addresses, title, if any,

and, if no title, a brief description of the subject matter of the document and its present or last known location and custodian.

13. The term "communication" or "communications" means any of the following: (a) any written letter, memorandum or other document; (b) any telephone call between two or more persons, whether or not such call was by chance or prearranged, formal or informal; (c) any conversation or meeting between two or more persons, whether or not such a contact was by chance or prearranged, formal or informal; and (d) any electronic mail, voice mail, telegraph, tape or video recording, data message and any other method or medium of communicating knowledge.

14. The term "or" is used inclusively to mean "and/or."

15. The term "Complaint" refers to the Complaint for Damages you filed in Stillwell et al. v. MultiCare Health System et al. with the Superior Court for the State of Washington in and for the County of Pierce, No. 11-2-05609-6, which case was removed to the United States District Court for the Western District of Washington at Tacoma, No. 3:11-cv-05117-BHS.

15. The term "TGH" refers in each instance to Tacoma General Hospital, operated by Defendant MHS in Tacoma, Washington.

THESE DISCOVERY REQUESTS ARE CONTINUING IN NATURE, AND IN THE EVENT YOU DISCOVER FURTHER INFORMATION THAT IS RESPONSIVE TO THESE DISCOVERY REQUESTS, YOU ARE TO SUPPLEMENT YOUR ANSWERS AND RESPONSES.

## INTERROGTORIES AND REQUESTS FOR PRODUCTION OF DOCUMENTS

**INTERROGATORY NO. 1:** Please identify all individuals who may have knowledge of facts relevant to any of the claims or defenses raised in this litigation, and, as to each such



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individual, identify the individual's current address and telephone number, describe the substance of the relevant information regarding which the individual may have knowledge, and identify whether you anticipate calling the individual as a witness at trial.

**ANSWER:**

1. Linda Stillwell 615 N. Sheridan Ave. Registered Nurse, Certified in Adult/ Tacoma, WA. 98403 Medical Nursing
253 627 6144

LS has knowledge of all her claims. How LS treated patients and fulfilled her commitment to her Employer, TGH (MHS). LS has knowledge of her damages.

2. Cherie Griffith 14118 141st Ave. KPN Registered Nurse
Gig Harbor, WA. 98329
253 884 5352 Work # 253 403 1106

CG has knowledge of the Plaintiff's skills, knowledge, professionalism and CG has knowledge of Manager, SC' s discriminating, bullying and disparity in treatment suffered by LS.

3. Sharon (Cheri) Cochrane 4507 60TH Ave. W. Registered Nurse
University Place, WA. 98466
253 564 0637 Work # 253 403 1106

S©C has knowledge of the Plaintiff's skills, knowledge, professionalism and has knowledge of Manager, SC' s discriminating, bullying and the disparity in treatment suffered by LS.

4. Linda Radawick Registered Nurse
Spanaway, WA.
253 531 8541 Cell: 360 458 1317 Work # 253 403 1106

suffered by LS.

9. Marina Podolskaya — Registered Nurse ( works at Good Samaritan Hospital Puyallup, WA.

MP has knowledge of Plaintiff's skills, knowledge, professionalism and has knowledge of Manager, SC' s discriminating, bullying and the disparity in treatment suffered by LS.

10. Tammy Wiggins — Registered Nurse

Moved to Arkansas 2010

TW has knowledge of Plaintiff's skills, knowledge, professionalism and has knowledge of Manager, SC' s discriminating, bullying and the disparity in treatment suffered by LS.

11. Rhonda Davis — Registered Nurse

Work # 253 403 1106

RD has knowledge of the Plaintiff's skills, knowledge, professionalism and has knowledge of Manager SC' s discriminating, bullying and the disparity in treatment suffered by LS.

12. Filipina (Fia) Lumanlan — Registered Nurse

Work # 253 403 1106

FL has knowledge of the Plaintiff's skills, knowledge, professionalism and has knowledge of Manager SC's discriminating, bullying, and the disparity in treatment suffered by LS.



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13. Kim Armstrong 6346 SE Autumn Lane Registered Nurse
Olalla, WA. 98359
253 857 3652 Work # 253 403 1032

KA has knowledge of the Plaintiff's skills, knowledge, professionalism and has knowledge of Manager, SC' s discriminating, bullying and the disparity in treatment suffered by LS.

14. Amie Nichols Registered Nurse

Work # 253 403 1115
253 241 4104
253 761 2197

AN has knowledge of the Plaintiff's skills, knowledge, professionalism and has knowledge of Manager SC' s discriminating, bullying and the disparity in treatment suffered by LS.

15. Hanna Welander 575 Andover Park West Suite 101 Nurse Representative
Seattle, WA. 98188
206 575 7979 Ext: 3035

HW has knowledge of the Plaintiff's skills, knowledge, professionalism and has knowledge of Manager, SC' s discriminating, bullying and the disparity in treatment suffered by LS.

16. Sally Baque 6346 SE Autumn Lane Registered Nurse
Olalla, WA. 98359
253 857 3652 Work #: 253 403 1024

SB has knowledge of the Plaintiff's skills, knowledge, professionalism and has knowledge of Manager, SC' s discriminating, bullying and the disparity in treatment suffered by LS.

17. Amber French 4312 Brookdale Rd E HUC (Secretary)
Tacoma, WA. 98446
253 414 3973 Work # 253 403 9530

AF has knowledge of the Plaintiff's skills, knowledge, professionalism and has knowledge of Manager, SC' s discriminating, bullying and the disparity in treatment suffered by LS.

18. Robin (Erlichman) Finnick 8410 Northway SW Patient Care Technician
Lakewood, WA. 98498 (PCT)
253 861 0167 Work # 253 403 1106

R(E)F has knowledge of the Plaintiff's skills, knowledge, professionalism and has knowledge of the Manager, SC' s discriminating, bullying and the disparity in treatment suffered by LS.

19. Sandy Lucus Patient Care Technician (PCT)
Retired December 2010
253 970 9373

SL has knowledge of the Plaintiff's skills, knowledge, professionalism and has knowledge of the Manager, SC' s discriminating, bullying and the disparity in treatment suffered by LS.

20. Wendy Taylor P. O. Box 7620 Patient Care Technician (PCT)
Tacoma, WA. 98417
253 759 3290

WT has knowledge of the Plaintiff's skills, knowledge, professionalism and has knowledge of the Manager, SC' s discriminating, bullying and the disparity in treatment suffered by LS.

21. Lakisha Davis 5530 Boston Ave. SW D2 Patient Care Technician (PCT)


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Lakewood, WA. 98499

LD has knowledge of the plaintiff's skills, knowledge, professionalism and has knowledge of the Manager, SC' s discriminating, bullying and the disparity in treatment suffered by LS.

22. Elisa Garza 915 6th Ave. TCM Physician Assistant
Tacoma, WA. 98405
253 403 7277

EG has knowledge of Plaintiff's skills, knowledge, professionalism and has knowledge of Manager SC' s discriminating, bullying and the disparity in treatment suffered by LS.

23. James Fry 315 M. L. .K Jr. Way Physician (Retired July 2011)
Tacoma, WA. 98405
253 403 4844

JF, Plaintiff's personal Physician, has knowledge of Plaintiff's skills, knowledge, professionalism and has knowledge of Manager, SC' s discriminating, bullying and the disparity in treatment suffered by LS.

24. Karen Nelson 314 M. L. K. Jr. Way #400 Physician
Tacoma, WA. 98405
253 627 0666

KN, Plaintiff's personal Physician, has knowledge of Plaintiff's skills, knowledge, professionalism and has knowledge of Manager, SC' s discriminating, bullying and the disparity in treatment suffered by LS.

25. Jennifer Permann 314 M. L. K. Jr. Way #400 Physician Assistant
Tacoma, WA. 98405
253 627 0666

JP, Plaintiff's personal Physician Assistant, has knowledge of Plaintiff's skills, knowledge, professionalism and has knowledge of Manger, SC' s

discriminating, bullying and the disparity in treatment suffered by LS.

26. Virginia Stowell 3124 S. 19th Street Ste #220 General Surgeon Physician
Tacoma, WA. 98405 253 301 5050
VS, MD, FACS, has knowledge of Plaintiff's skills, knowledge, professionalism and has knowledge of Manager, SC' s discriminating, bullying and the disparity in treatment suffered by LS.

27. Diane Cecchettini 315 M. L. K. Jr. Way C.E.O. TGH/ MHS
Tacoma, WA. 98406 253 403 1000
DC, C.E.O., has knowledge of Plaintiff's skills, knowledge, professionalism and has knowledge of Manager, SC' s discriminating, bullying and the disparity in treatment suffered by LS.

**REQUEST FOR PRODUCTION NO. 1:** Please produce all documents and/or electronically stored information that reflect, describe, support, or relate to your response to Interrogatory No. 1 above.

**RESPONSE:**

**REQUEST FOR PRODUCTION NO. 2:** Please produce all documents and/or electronically stored information that reflect, describe, support, or relate to your allegations in

Paragraph 2.9 of your Complaint that Plaintiff Linda Stillwell "received numerous commendations, thank yours [sic], and positive comments from the patients and their families whom she cared for."

**RESPONSE:**

**INTERROGATORY NO. 2:** Please describe each and every instance when you raised, filed, submitted, or lodged complaints, concerns, or allegations with Defendant MHS or its employees regarding: (1) "the amount of work that [you] and [your] co-workers were required to complete;" (2) you and your co-workers "becoming overwhelmed" with "the implementation of a new electronic charting system known as EPIC;" (3) "the increased number of patients and their increased acuity needs;" (4) your alleged inability "to take breaks and lunches;" (5) "unsafe working conditions;" and/or (6) "issues relating to the safety of patients and the stress on [MHS's] employees," as alleged in Paragraphs 2.12 through 2.18 of your Complaint. As to each such instance, provide the date/s on which you raised such concerns, the individual/s with whom those concerns were discussed, and the substance and outcome of each such discussion.

**ANSWER:**

I will state that I complained a number of times regarding breaks and lunches, working conditions that were unsafe, and other issues that I felt resulted in safety concerns for staff and patients. I cannot recall at this time all of the conversations, and I believe there are more than I have listed, but I attempt to provide as many as I can recall at the present time below. I believe there were many additional times when I mentioned these issues.

1. DATE: November 2008, Staff Meeting

INDIVIDUAL discussed concerns with: S.C., Manager



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INSTANCE: Manager stated to myself and SSU/SAU staff, "I want all of you to know my door is always open to hear any concerns you have". I spoke at meeting concerning learning the new Epic system of documentation was stressful and that I was doing my best to not make any errors. I presented that lack of breaks and missed lunches made it more likely to make mistakes. I complained of lack of breaks and missed lunches.

OUTCOME: The Epic System continued in the process of being implemented. Constant changes and additional ways to utilize screens in Epic continued. Breaks and lunches continued to be missed without reimbursement.

2. DATE: December 11, 2008 LS requested meeting

INDIVIDUAL discussed concerns with: SC, Manager and TL, Director

INSTANCE: I reviewed with my Managers my concern of being assigned patients with increased acuity needs as well as how that impounded myself and my Co-Workers. I provided example of my work assignment to show especially how the number and types of medications the patients received indicated the various medical conditions they were receiving treatment for. Only two out of my six assigned patients were actually Ambulatory Care Unit acuity patients. I reported that Doctors had stated to me such remarks as, 'Why is my patient here when they need a longer recovery time?, and "What is going on?". I presented that the additional time it took to enter documentation in Epic and the dual documentation of the Discharge process (both in Epic and paper documentation) was causing overtime.

OUTCOME: No immediate change. Ratio of patients to RN was addressed by end of February,2009 and was documented in Management's response March 31st, 2010 to Grievance LS filed 12/2/2009 for Termination without Just Cause , quote, "work load issues were also brought to SC by several of Linda's peers. The concerns prompted SC to lower the Nurse to patient ratio on the unit from 8 patients to 1 RN to 5-6 patients to 1 RN. Of Note: This came two months after LS had brought concerns to Manager and that all staff became verbal in the January, 2009 staff meeting.

3. DATE: December 2008 Staff Meeting

INDIVIDUALS to who and with whom discussed: SC, Manager



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INSTANCE: SC reported to staff that audit of the Emar documentation in Epic would be on going. LS raised concerns as to the patient to RN ratio and the increased acuity needs (more medical conditions in addition to the surgical needs each had) were causing more overtime, patient safety issues, increased possibility of errors, and increased stress levels for all staff.

OUTCOME: No change

4. DATE: January 22, 2009

INDIVIDUALS with who or whom concerns were discussed: SC, Manager

INSTANCE: LS met with SC per LS' s request to discuss work assignment. LS was assigned to partner with a PCT who was floated into the unit and the PCT was not trained in the Epic documentation for the SSU/SAU. LS reported concerns about increased acuity of the patients, lack of breaks and missed lunch, increased time documentation required, forced overtime, and that patient safety could be impounded due to increased likelihood of mistakes. LS reported that patient's safety was dependent on her and her Co-workers. LS, being her units WSNA Representative, expressed concerns staff had expressed about being overwhelmed due to an inordinate amount of stress on a daily basis. LS expressed that she had longevity with many of the staff (10-20 years average) and testified to the character and attributes of her Co-workers. LS expressed that several of the staff felt little support from management during such a challenging period of time.

OUTCOME: When LS requested that concerns be submitted in writing, SC responded that concerns would be noted and presented to Director, TL. When LS requested that SC initial written documentation of LS' s work assignment on 1/22/2009, SC declined.

5. DATE: February 5th, 2009

INDIVIDUAL/S CONCERNS DISCUSSED: SC, Manager, TL, Director

INSTANCE: LS was reviewed as to 1/21/2009 patient's wife being upset when asked to "sit in chair or leave the room" on patient's arrival to room from PACU (Post Anesthesia Care Unit) and 2/4/2009 when per SC young patient's mother alleged complaint that LS had been dismissive to her. LS responded that on 1/21/2009 no AM or PM break had been taken and that



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impounds delivery of care and that LS was in process of assessing patient's breath sounds and due to patient's wife talking with her husband it was preventing that crucial assessment to be accomplished and LS responded that young patient's mother was exhausted per her own statement that she had not been able to get any sleep and that she was upset that her son had a 6 hour wait in the ED (Emergency Department) and that she expressed that she had little faith in her son's Doctor's attentiveness and that LS had not been dismissive to her concerns and emotional needs and that in fact, the Manager was requested to intervene to hear this mother's frustrations with her son's hospital experience. LS reported that increased acuity needs of assigned patients made it difficult to meet the needs of the Ambulatory patient population. OUTCOME: LS was told to review MHS policy on behavioral expectations and was directed to report each shift to SC, Manager before 12 Noon on the discharge status of each of her assigned patients.

6. DATE: February 6th, 2009

INDIVIDALS with who or whom concerns were discussed: SC, Manager and TL, Director INSTANCE: LS was issued a STEP III Discipline for the omission of medication documentation in the Emar record in Epic. There was no medication error. The 5 rights of medication administration were followed correctly. There was no harm to the patient. The date of the omission on this one patient (after a period of Emar audit extending from October, 2008 to present) was January 30th, 2009 and less than 30 days since the end of the orientation period for the implementation of the new electronic chart. In the Discipline it is written that failure to document prn (as needed) narcotic administrations places the patient at risk of receiving additional doses of narcotics which could result in respiratory compromise. Per Pyxis (the machine that stores the medications on the unit), this patient's medications were obtained at 09:20AM and per documentation in Epic, this patient was discharged to home with stable vitals and baseline neurological status at 10:35AM. In this patient's hospital course there was no possible "WHAT IF" due to the fact he was discharged after one hour of receiving his ordered medications (of record the medications this patient received were not new to him, having a ten year history of narcotic medical intervention and a baseline of high narcotic tolerance). In the



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STEP III Discipline it is written that "this progressive guidance was imposed after investigation was done". LS asked why no progressive action, WHY A MOST SEVERE DISCIPLINE WHEN NO PRIOR STEP I OR STEP II? LS asked why being disciplined on the worst outcome when that WHAT IF could not and did not occur with this patient? LS asked if every RN, who had omitted entries in the Emar and had not followed MHS Medication Administration Policy, were issued a STEP III Discipline.

OUTCOME: No change in management's choice to issue to LS the most severe of Disciplines. No real investigation by management. LS presented that the day of this omission was a Saturday. The other facts are as follows: 1. There is decreased staff assigned to work on Saturday shift. No HUC, therefore ,no one at desk to answer phones or enter charges. No Housekeeping staff on duty to assist with transfer and discharge of patients. The Housekeeping staff come after all patients are gone or come in on Sunday and clean prior to the unit reopening on Monday. 2. LS was orientating RN, RD, to Saturday routine of how to close the unit, how to enter charges and how to correctly capture the total hours each patient's stay totaled.

3.Presented that patient received correct medications, correct dosages, correct time, correct route and to the correct patient. 4. Patient was never at risk. 5. Patient was discharged over one full hour after receiving his ordered medications, and the patient was

discharged with stable vital signs and baseline neurological status as documented in Epic.

6.No staff followed LS due to this patient discharged to home. 7. There was no prior omission of documentation of any administered narcotic by LS prior to 1/30/2009 even with audit of Emar since October, 2008. 8. LS HAD NO PRIOR STEP I OR STEP II OR STEP III (None issued since transferring in to Unit in September, 2005 and none throughout the 25 years prior to that). LS followed after RN staff that repeatedly omitted entering documentation of narcotic and medications in the Emar and these staff members did not receive STEP III Disciplines per their own testimony and per documentation provided to WSNA. LS' s emotional outcome from this discipline was an overwhelming feeling of being singled out and targeted. LS experienced a hostile work environment and felt silenced from expressing any further concerns about workload, forced overtime, lack of breaks and missed lunches, and patient safety issues. LS felt that her Manager was determined to eliminate LS' s top of the pay scale wage that LS was at due to longevity with TGH (MHS). It brought back to mind the statement SC had stated at the very

first staff meeting (when SC was introduced), that her prior management experience was in Banking and that with the 3 separate mergers that had taken place, she was the one who "fired people". It is fact, by reducing the Budget on the Unit, SC receives a larger Bonus and gains greater recognition.

7. DATE: February 13, 2009

INDIVIDUAL/S to whom concern discussed: SC, Manager

INSTANCE: Brief exchange where LS was told of need for continued daily reporting to SC of the discharge status of her assigned patients before 12 Noon.

OUTCOME: LS responded that she was compliant with Management's directive and that had in fact paged Manager to provide report when Manager was not on the Unit. LS asked if all RN staff that had Overtime were asked to comply to this directive. No response given by SC to this inquiry.

8. DATE: June 10th, 2009

INDIVIDUALS TO WHO AND WITH WHOM DISCUSSED: SC, Manager, and NO, Manager of PACU.

INSTANCE: On May 6th, 2009 LS was assigned a Student Nurse to preceept ( of note LS was not paid preceptor pay for this shift). On May 6th, 2009 the Student Nurse, CH, lodged a verbal complaint against, Plaintiff, LS. Student Nurse, CH, was asked by SC, Manager, to write a letter of complaint. Between May 6th,2009 and June 10th, 2009 there were no verbal or written complaints made by any patients, family members or students that LS had any contact with. On June 3rd, 2009 SG, Manager informed LS that due to Managements decision to switch assigned Saturday shift (for no reason other than Management's choice) that since this switch would result in LS working two consecutive Saturdays, Management could take LS off the schedule for June 13th, 2009. LS responded "I need to work my assigned FTE hours". On June 10th, 2009, 34 days after Student Nurse, CH's complaint, SC with Director, TL's support, issued a STEP III Discipline to LS for: Failure to follow behavioral expectations, Patient safety violation, Failure to create a positive learning environment and Failure to follow the 5 rights of medication administration. No prior STEP I or STEP II progressive discipline had been issued. In this Discipline, reference was made to January 21st, 2009 when LS had asked a patient's wife, on the



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patient's arrival out of PACU (Post Anesthesia Care Unit), "sit down or leave the room so she could finish her assessment of the patient". Of fact, LS had been given report on this patient's condition from the PACU RN and had been informed that this patient had emesis (threw up) when he was extubated (air way removed) and that his lungs were moist throughout and that his oxygen saturation was impaired. LS, as per her Registered Nurse responsibility to this patient, needed to assess his baseline on presentation to the Unit. It was alleged that LS' s request was the primary reason that this patient's wife was worried and upset. Also, in this Discipline, reference was made to February 4th, 2009 when LS was accused by a young patient's mother (per SC) of being "dismissive in her behavior towards her". It is of record that SC continued to assign this patient to LS for care for two more shifts following his mother's alleged statements. It is fact that PCT,SL had asked SC to intervene for this mother due to her expressing her frustration that her son had a 6 hour wait in the ED (Emergency Department) while he was in pain and that at 07:24AM (when this instance took place), the mother had had no sleep (her son had arrived to the Unit at 01:30AM after Surgery and PACU) and the mother had expressed to LS that she had "no faith in her son's Doctor's attentiveness". This mother's response was to LS when ,after the patient had had an emesis (threw up gastric contents and had scant amount of blood on tissue when he blew his nose), tried to reassure the mother that LS was going to go contact the patient's Doctor and give a condition report and find out when the Doctor was going to see her son. The patient's mother was speaking to LS as LS was in the patient's bathroom flushing the emesis down the toilet. After continuing to care for this patient and his mother, both expressed to LS their appreciation to her for her care and interventions on the young patient's behalf. As to the Student Nurse's letter of complaint, it is written that CH had not seen patient's Emar, yet the computer was open to this patient's chart in the Medication room where both LS and CH were present and LS directed CH to the information. The patient's medication, Ancef, was on the screen, the route IV (intravenous) was viewed and the time of administration noted and the dose of 1gram noted. It is from this information on the computer, in the Medication room, that the Student Nurse, with LS' s supervision, was able to mix the medication into a 50cc bag of Normal Saline solution and label the bag with the patient's name, room number, the date, the time, the name of the medication and the dose, prior to entering the patient's room. The Student Nurse alleged that LS logged her out of the patient's chart in the patient's room. The Student Nurse



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wrote that LS did not let her do the 5 rights of medication administration until after discussion in the patient's room that if the Student Nurse would feel more comfortable with her Instructor present that would be fine. LS based that on her experience that many times due to a student's anxiety the student learns best with their Instructors. The facts are the 5 rights of medication administration were followed as evident in the documentation in the Emar. The Student Nurse, CH, manifested to LS that she was nervous. LS did not engage with CH in an angry manner, and LS 's only intention was for the Student Nurse to have "hands on" clinical experience. CH had spent two hours on the computer at the Nurse's station and had left the ward twice for extended periods of time. It was after 01:00PM, and CH had received very limited clinical experience by that time. Student Nurse, CH, wrote that she had remained in the room with the patient, whereas LS 's testimony is that LS remained with her patient and communicated with her patient as to what had transpired. LS expressed to her patient that I was sorry that I was not effective in allaying this student's anxiety. The patient expressed to LS that she could see that she was trying to help the student. LS expressed to the patient how I wanted the student to benefit from doing the process of identifying the patient, administering the medication using the 5 rights, checking a saline lock ,priming the tubing and setting the pump as well as documentation in the Emar. The patient stated to LS she saw how the student did not seem to be reassured and receptive. The patient's safety was never at risk. LS conducted herself in a professional manner with a very nervous and inexperienced individual. In responding to this Discipline, LS asked, "Do all staff receive a STEP III Discipline without receiving a STEP I or a STEP II Progressive Discipline and do all staff receive a STEP III Discipline based on patients being distraught (four months prior) and a Student Nurse being anxious?". SC also issued with this Discipline a 3 day suspension without pay that correlated to the Management's assigned consecutive Saturday shifts for LS( thus eliminating consecutive pay for LS).This made it economically better for SC's budget by not paying LS consecutive Saturday's pay that is stipulated in the contract between WSNA and TGH.. No other staff received Discipline before June 10th, 2009 for these type of alleged events, even though there were complaints ,that LS and Management were aware of ,concerning other staff members from patients and their families. LS' s emotional outcome from this discipline was an overwhelming feeling of being singled out and targeted. LS experienced a hostile work environment and felt silenced from expressing any further concerns about



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workload, forced overtime, lack of breaks and missed lunches, and patient safety issues. LS felt that her Manager was determined to eliminate LS' s top of the pay scale wage that LS was at due to longevity with TGH (MHS).

OUTCOME: Again, threat of Termination and disparate treatment. Again, LS feeling discriminated towards due to age and being at the top of wage scale. LS had over 30 years employment with TGH during which LS provided teaching to a multitude of Student Nurses, new hires, return to duty hires, and Agency staff. LS had never had any verbal complaints or written complaints. In fact, LS received verbal and /or written appreciation with each occasion. On June 11th, 2009, LS filed a Discipline Without Just Cause Grievance. It was at this time that HW, WSNA Nurse Representative, stated to LS, "SC is going to fire you. Why don't you quit, find a new, better place to work and go on with your life and be happy?". LS put trust in WSNA ,despite this ,to represent her and remove the STEP III Disciplines that were not warranted, were not progressive as agreed upon in the contract between WSNA and TGH and were, in fact, examples of Management treating LS NOT IN ACCORDANCE to TGH' s Patient Safety Culture, TGH' s Corporate Compliance or TGH' s Code of Conduct.

8. DATE: August 7th, 2009

INDIVIDUAL to whom discussed concerns: SC, Manager

INSTANCE: SC presented LS with her yearly job Performance Evaluation. LS discussed with SC that she had had no complaints since February 4th, 2009 from any other patient's families and never any complaints from patients and no further Student Nurse complaints since the one complaint made on May 6th, 2009. LS discussed that the remainder of May, all of June and July there was sustained improvements in all areas (no medication errors or omissions also) and again, never any harm to any patient assigned to LS for their care. SC, Manager informed LS that the reason a STEP III Discipline was issued 2/6/2009 was not due to LS' s omission in the Emar, but that it was that the patient was not made to remain in the hospital after taking his prescribed narcotics. LS asked SC, Manger, how long patient would have had to remain in the hospital? SC responded that LS needed to have patient agree to remain one hour after he received his medications. LS asked if there were any written policy to follow for this situation. There is no written policy. LS asked, "What if that made the patient and his wife angry?" SC instructed LS



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that she only needed to document her reasons in the Nurse's Notes and that would counter any written letter of complaint. LS asked SC to review this patient's chart because LS knew that the medications were given at 09:20AM and the patient was discharged to home at 10:35AM (this patient had remained over one hour).

OUTCOME: No review of documentation in patient's chart as requested by LS. In LS' s Evaluation , LS was evaluated at Level 1 (lowest) for "Purse Excellence and Creativity and Promote change to make things better" despite fact that LS maintained her continuing education (stood out on the Unit for having her Certification in Medical/Surgical Nursing). LS was evaluated at Level 1 for "Take responsibility for Service & Quality" despite fact that on a daily bases LS strove for excellence, did no harm and maintained safety precautions and procedures. LS was evaluated at Level 1 for "Show respect for the people and the Organization" despite fact that LS had no complaints from families since February 4th, 2009 and no further complaint from any Student population and had showed sustained improvement and had never received any complaint from any patient assigned to her for care. LS expressed to SC that she was in disagreement with the Evaluation and that by signing it she was only acknowledging that she had received it. SC stated to LS at that time, "With your 30 plus years you should consider retiring". LS' s emotional outcome from this discipline was an overwhelming feeling of being singled out and targeted. LS experienced a hostile work environment and felt silenced from expressing any further concerns about workload, forced overtime, lack of breaks and missed lunches, and patient safety issues. LS felt that her Manager was determined to eliminate LS' s top of the pay scale wage that LS was at due to longevity with TGH (MHS).

9. DATE: November 19th, 2009

INDIVIDUAL TO WHOM DISCUSSED CONCERNS: SC, Manager

INSTANCE: LS discussed with SC concerns about the actions of PCT, LC with whom LS was partnered with for 3 shifts. PCT, LC, was in new position working the Ambulatory side of the Unit. The following was presented: 1. November 13, 2009: LS was in an Isolation room providing care to the patient when LC opened the door, stood in the doorway, and began to discuss another patient's needs. LS directed her to go to the charge RN, CJ, to get assistance. LS wanted HIPAA regulations adhered to. 2. November 18, 2009: PCT, LC, stated to RN, CJ, who



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was Charge Nurse, that LS had directed her to review (Room 428) discharge instructions with the patient. The Charge Nurse discussed this with LS since the PCT role does not include reviewing home instructions. CJ, Charge Nurse, stated that since PCT, LC, was new to working on the Ambulatory side perhaps LC did things differently on the Short Stay side. CJ also stated she thought it was unusual that LS would have changed her practice. LS stated to CJ that LC had not been directed to go over Discharge Instructions with the patient. On this same shift, PCT, LC, left the Ambulatory Care Unit and went out of the building and down to the corner to take a patient's prescriptions to the Multicare Pharmacy. PCT, LC, who was partnered with LS, never told LS or any staff person that she was leaving. When LC returned, LS spoke with LC privately and requested that if she were leaving the Unit she needed to report off. LC replied, "No worry, it was my lunch break". 3. November 19th, 2009: PCT, LC, did not follow through with "plan of care" as directed by LS during AM report session as to ambulation of assigned post-operative patients. These examples were given: Room 420: LS asked patient, at the time discharge instructions were being reviewed, how had she tolerated ambulating in the hall? And the patient responded that no one had assisted her to walk out in the halls since 04:00 AM (it was 12 noon when the discharge was about to take place). Room 422: This was the first time that this patient had ever had surgery. When LS asked how this patient was tolerating walking in the hallway, she responded that no one had offered to walk with her and she did not feel safe walking by herself. LS ambulated patient full distance of hallway with stand by assist. Room 424: Patient told LS that she had not been assisted to walk in the halls. She said she had been helped up to sit in a chair. LS ambulated patient with stand by assist full distance of hallway and was concerned that perhaps due to patient's lack of activity (PCT not following plan of care) was not the reason she failed her Voiding Trial and had to have a Foley catheter replaced.

4. November 19th, 2009: LS discussed with SC, Manager, that the two Housekeeping staff, MB and IT, had come to LS due to fact LS was partnered that shift with PCT, LC and expressed that they were unhappy due to being treated in a rude manner when PCT, LC interacted with them concerning "beds being made up faster" (BEDS REQUIRE A CERTAIN LENGTH OF TIME TO DRY) and also concerning the food in the pantry. LS told SC, Manager that LS directed both of the staff to go to SC, Manager with their concerns and also to express their feelings directly to PCT,LC whenever she interacted with them in a negative manner.

OUTCOME: SC stated to LS that SC was investigating a complaint and planned to have meeting with LS on 11/20/2009 after her shift. LS inquired as to what the complaint was about and SC told her it was not to be discussed at this time. LS stated concerns as listed. SC, Manager stated to LS, "You can discuss concerns with me at any time." SC then stated to Plaintiff, LS, "Linda, you are a good Nurse.

10. DATE: November 20, 2009

INDIVIDUAL with whom discussed concerns: SC, Manager

INSTANCE: LS had the following concerns that were discussed with SC, Manager at approximately 1400. These concerns were concerning additional actions of PCT, LC who was partnered with LS this shift that were inappropriate: 1. PCT,LC came into Room423 while LS was documenting in Epic and began to discuss another patient's care. LS had to exit out of Epic and go out into hall and again ask LC not to discuss other patient's needs in front of another patient. 2. PVT.LC came into Room 424 while LS was engaged in reviewing this patient's Discharge Instructions and started to talk with LS about the patient in Room 423. LS had to excuse herself from patient and go out into the hall and again request that LC should only say, "I need to ask you a question or tell something", and I can respond in a timely manner and that HIPAA rights are maintained. 3. Patient in Room424 stated to LS that PCT,LC "shoved ice pack down her back" while she was sitting in the upright position in the bed and that "it hurt" (the type of ice packs on 4JII, due to the size of the ice, cannot be over filled and the only way the ice pack should be applied to post op back patients is to position the patient on their side with a pillow between their legs and place the ice pack against their dressing and placing another pillow to their back to support the ice pack and keep it in place). The patient expressed to LS, "I didn't want to argue with her." 4. The patient in 423 told LS, "the PCT, LC made me use the I.S. (Incentive Spirometer) EVEN when I told her I had just done my breathing exercises. She intimidates me."

OUTCOME: SC listened. Restated to LS that meeting would take place after 15:30 .

11. DATE: November 20th, 2009



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INDIVIDUALS to who and with whom discussed concerns: SC, TL, AN (WSNA Representative), SB (WSNA Representative)

INSTANCE: Meeting took place at 15:45. LS was informed that PCT, LC and C.N.A.,TK, stated to SC that LS put pressure on patient's ( Room 415-2 ) post-operative ankle and that they did not hear LS say she was sorry. LS responded that she did say she was sorry and that causing discomfort to the patient caused LS to feel distressed. LS reported that she went in 415-2 to communicate to LC (LS' s assigned partner) that since it was 11:45AM and LS had no AM break, LS wanted LC to know she was taking lunch break and that LS wanted LC to check on patient in 420 who had requested assistance when lunch trays were pasted. LS expressed that at no time were HIPAA Regulations not adhered to. LS expressed that she had no information as to what type of surgery the patient in 415-2 had since this patient was on the Short Stay side and that the bed was in the high position and it was unintentional that LS' s arm came in contact with the patient's foot. LS reported that she raised the covers and assessed the operative site (to make sure her inadvertently placing pressure had not caused any bleeding or injury) and that there was no bleeding noted and the toes were pink and warm to touch.

OUTCOME: LS submitted written response to concern.

12. DATE: November 20th, 2009

INDIVIDUAL/S TO WHOM DISCUSSED CONCERNS: SC, TL, AN,SB

INSTANCE: SC presented to LS that PCT,LC had told her that LS does not adhere to HIPAA rules and that makes LC feel uncomfortable. LS responded that LS does adhere to HIPAA regulations. LS responded that LS repeatedly had instances where LC did not follow HIPAA guidelines and that these concerns were discussed with SC on 11/19/2009 and 11/20/2009. SC did report that as part of her investigation she had interviewed four patients and that none of them had recalled any "of those types of conversations taking place in front of them" as LC had alleged.

OUTCOME: LS submitted written response that stated. "It is not my practice to discuss other patient's needs (private information) in front of patients".

13. DATE: November 20th, 2009



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INDIVIDUAL/S TO WHOM DISCUSSED CONCERN: SC, TL, AN, SB

INSTANCE: SC stated that LS had interrupted PCT, LC, during a personal phone call she was having while on duty at the Nurse's Station. SC reported that LC had gotten special permission from SC to engage in this call.

OUTCOME: It was presented by AN and SB and LS, that when on duty and a staff member needs assistance to help a patient ,the person who is requested to help is the staff member's assigned partner. LC was LS' s assigned partner ,and it is practice that if a staff member is on a personal call while on duty, that call needs to be interrupted. It was asked, " Why was LS, LC' s assigned partner, NOT informed of this phone call that SC, Manager had given LC permission to receive?"

14. DATE: December 1st, 2009

INDIVIDUALS concern discussed with: SC, Manager, TL, Director

INSTANCE: Management met with LS at 06:50AM (on the AM of LS' s assigned shift) and stated to her, " It was a difficult decision, but you are terminated from your employment at TGH immediately. You must hand over your Badge and clear out your locker and do not go onto Unit". LS asked for reason for Termination and the only response was " it was a difficult decision". LS 's only additional comment was, "You have not seen any good in my service?" and when asked if LS had any papers with any patient's private information, LS offered for Management to see the contents of her locker and her bag.

OUTCOME: TL informed LS that the Management had 7 days to provide her with the reason/s for her Termination. LS put her request in writing and had it notarized by Human Resources Department. LS filed a Grievance for Termination Without Just Cause on December 2nd, 2009.

15. DATE: December 7th, 2009

INDIVIDUAL concerns were discussed with: DC, CEO OF MHS

INSTANCE: DC, CEO OF MHS granted 15 minute meeting that was extended to 45 minutes. LS presented her appreciation for the privilege of serving at TGH for 31 years and thanked her CEO for being such a wonderful role model and positive force for the Community. LS presented her concern as to SC's, with TL's support ,maintaining an environment that was punitive and

threatening and that LS was discriminated against due to her age and wage. LS presented to her CEO that there was no gross negligence on her part and no willful misconduct.
OUTCOME: DC,CEO expressed shock at the notification. that the Nurse she knew of personally to be dedicated and held in high esteem ,was being separated from her employment with TGH. DC, CEO stated she would "look it to this".
If it were not due to my age, my union activity, and my complaints, and the retaliation that came as a result of those complaints, and the discipline that came as a result of those complaints, it is my belief that I would still be employed.

**REQUEST FOR PRODUCTION NO. 3:** Please produce all documents and/or electronically stored information that reflect, describe, support, or relate to your answer to Interrogatory No. 2, above, including, but not limited to, any and all written complaints, concerns, or allegations that you filed, submitted, or provided to Defendant MHS or its employees.

**RESPONSE:**

**REQUEST FOR PRODUCTION NO. 4:** Please produce all documents and/or electronically stored information that reflect, describe, support, or relate to your allegations in Paragraph 2.12 of your Complaint that you were "not able to take breaks and lunches as required under Washington law."

**RESPONSE:**


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**INTERROGATORY NO. 3:** Please describe each and every instance when you raised, filed, submitted, or lodged complaints, concerns, or allegations during your employment with MHS that you "though that Ms. Chance was singling [you] out for unfair and disparate treatment." As to each such instance, provide the date/s on which you raised such concerns, the individual/s with whom those concerns were discussed, and the substance and outcome of each such discussion.

**ANSWER:**

1. DATE: November 13th, 2009: Singled LS out as being "the problem". LS requested to meet with SC due to concern as to how Traveler RN, RJ, had spoken to LS in front of a patient and his family.

INDIVIDUALS WITH WHOM DISCUSSED: SC, Manager, TL, Director, RJ, Traveler RN

INSTANCE: RJ, who LS had witnessed on four occasions upset his patients and their families {including events where Hospital Representatives had been called in to intervene), had told LS ,in front of patient and patient's family, to leave patient's room.

TL, with SC' s agreement, told LS, "you should ask RJ what "he wants you to do " when his patient's call for help". LS had presented to management that she was at the Nurse's Station when a family member for the patient in Room 423 asked for assistance. LS offered to get the assigned Nurse and the family member replied that the assigned Nurse had been asked 3 times and had not assisted the patient. LS went in Room 423 and assisted the patient (as LS' s training and practice for over 30 years was "all patients are every ones concern and a response of "that is not my patient" has never been acceptable).

In the meeting, LS asked the question as she had been directed to and RJ responded, "Do not help my patients. TL, with SC' s agreement, stated, "Linda, there is your answer".



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OUTCOME: LS was treated as if her concern held no merit. LS was not valued for her professional judgment. True patient advocacy requires that Nurses confront their peers and promote professional practice in all environments. LS had never been taught to advocate only for those patients assigned to her. LS felt singled out as the problem, whereas, LS' s goal had always been to be part of the solution. Following this meeting, Dr. William Morris, Dr. Peter Brown and Dr. Anthony Harris informed Management that Traveler RN, RJ, could not be assigned to their patients. As a result of this, all RN' s, on the Ambulatory Care Unit, had their daily assignments adjusted to accommodate caring for these Physicians' patients. Also, RJ announced that SC "wrote a letter to my Agency critical of my performance and now the assignment I had lined up to do after my contact is done here at TGH has been cancelled". Even with SC' s critical evaluation of RJ's performance and safety, RJ was allowed to finish his contracted weeks with TGH.

2. DATE: December 10th, 2009. LS was singled out as not providing Discharge Instructions "fast enough".

INDIVIDUAL/S TO WHOM CONCERNS DISCUSSED: SC, Manager

INSTANCE: LS was at Nurse's Station making a "Real Time" documentation in Epic when SC told LS in harsh, critical manner "go discharge your patient in 428". Then SC stated " IF you are not going to discharge your patient NOW, find someone else to do it!".

OUTCOME: I requested and was granted a meeting with SC after the end of my shift. LS stated to SC that her assignment was well organized, that her patient's duplicate Discharge Papers were ready and that LS' s patient's discharge from the hospital was accomplished in a safe and timely manner. LS requested that SC not INCREASE LS' s STRESS (learning Epic is stressful!) and that LS would appreciate that if SC had found that LS had in fact delayed her patient's discharge, that SC would discuss this event with LS after SC knew it had OCCURRED. SC responded "I know I tend to just say things as I am thinking it or I tend to forget". LS never observed or was provided testimony that SC interacted with any other RN on Duty in that manner during the length of time SC was LS' s Manager (September, 2008 - November, 2009). The following RN's testified to LS that they were not treated in this manner and had never been



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directed to stop a Real Time entry in Epic to do a task NOW: RN, LR RN,S©C RN,RD RN,FL, RN,CJ .

3. DATE: January 9th, 2009. LS was singled out as to being responsible solely for not getting to take breaks and lunch.

INDIVIDUAL/S TO WHOM CONCERNS DISCUSSED: SC

INSTANCE: SC stated to LS, "the reason you don't get a break is you "can't let go", "you don't ask for help", you are too set in your ways". LS never witnessed or was provided testimony that SC spoke with another RN or judged any other RN in that manner. LS interviewed the following Co-Workers: RN, LR, RN, S©C RN, RD RN,FL RN,CJ RN,DD RN,ZC. LS was knowledgeable of RN staff not getting to take their paid two 15 minute breaks or their 30 minute lunches.

OUTCOME: LS perceived that SC was treating her in a disparate manner and that SC dismissed the factors that were the true reasons for missed breaks and lunches: increased acuity needs of the patients SC accepted on the Ambulatory Care Unit, increased length of time documentation in the new Epic system required, the increased length of time it took to complete the changed Discharge process, and the increased patient/RN ratio assignments that SC had implemented.

4. DATE: January 21st, 2009: LS was singled out by SC as sole cause of a post-operative patient's wife being upset.

INDIVIDUAL/S TO WHOM DISCUSSED CONCERN: SC, Manager, TL, Director

INSTANCE: LS was told by SC that LS had upset patient's wife when LS asked her to allow LS to assess her husband on his arrival from the PACU (Post Anesthesia Care Unit). LS reported to SC that LS observed the patient's wife greet her husband while he was on gurney in hallway and gave him a kiss. When patient was moved into his bed, PCT, R(E)F, DIRECTED PATIENT'S WIFE TO WAIT IN THE HALL and explained that staff needed to work with patient and needed to get him "Returned". PCT, R(E)F, FINISHED obtaining vital signs and obtaining patient's type of Full Liquids he would like and left room as LS was then instructing the patient about the Pain Scale and between 1-10 with 10 the most severe asking where he was on this scale. LS was in process of instructing patient on the importance of taking Deep Breaths, not

only to improve his lung status post anesthesia but in his particular situation from the Report LS had received from the RN in PACU, due to his having had an emesis (threw up) as his airway was being removed, he was at greater risk with moisture and wheeze audible in his upper quadrants. The patient's wife came into room and was asking her husband questions when LS requested of the wife to "have a seat ". The patient's wife left the room. PCT,R(E)F, came into room and reported to LS that she had asked TL, Director, to intervene for the patient's wife due to the patient's wife crying. LS thanked partner and proceeded to do what a competent RN must do and that is evaluate a patient's Baseline and try to provide for the patient the best foundation for successful recovery from the effects of anesthesia and best possible health outcome. LS , after the patient 's condition was assessed, then went to the patient's wife ,who was standing in the hall and up next to the wall and reported to her that her husband was doing well and ,at that time ,LS offered to get her juice and was sorry she had been detained.

OUTCOME: LS discussed with SC and TL events that had taken place and LS put in writing the events as she knew them to be. June 10th, 2009, five months later, in a STEP III Discipline given to LS, with no prior STEP I or STEP II, this event was written up by TL and SC. LS had personal knowledge and had witnessed other patients and patient family members expressing anger and emotions concerning other RN staff, and no other staff had received any STEP III as Discipline. TL alleged in this Discipline that the patient stated, "RN showed a non-caring attitude". LS reported that she only worked with this patient on his return to Unit (due to it being close to change of shift) and that in addition to total body assessment, LS had expressed her concern for his wellbeing, had provided him with oral care, had instructed him in use of the Incentive Spirometer and Deep Breath and Cough and had obtained a warm blanket for him from the Blanket Warmer. LS requested of TL and SC to consider that the patient's wife could have influenced his comment. Of the RN staff that LS was witness to and was known by SC and TL where other patients and their family members were upset and angry, (examples of patient's upset: RN, RD, and RN,CJ ) received no Discipline of any kind.

5. February 3rd, 2009: Singled LS out as not making the right assignments on Saturday shift when in Charge position.

INDIVIDUAL/S WITH WHOM CONCERN DISCUSSED: SC, Manager



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INSTANCE: LS spoke with SC and expressed that she was not able to take 15 minute breaks or lunch during the Saturday shift due to the added responsibility of orientating the other RN on duty to entering charges in Epic and the routine for closing the Unit and due to the acuity of the patients.

OUTCOME: SC stated to LS "you should not be in Charge position since you do not make out the assignments correctly". LS responded that the assignment of LS taking six patients with the PCT and assigning the second RN, RD, who was new to the Saturday position (enabling RD to be successful at entering charges and learning the tasks needed to close the Unit) to Primary Care for three patients was made in accordance to the established practice by all RN's on the Ambulatory Care Unit. LS presented that she had participated in this practice since September, 2005. SC informed LS that the correct way the assignment needed to be made was to divide the patients between the two RN's and assign the PCT on duty all nine patients for care (stating, "the patients can go home for their shower or have their hygiene needs provided on the Unit they were transferred to"). LS requested that if Management wanted to change the established staff assignment practice by the RN in the Charge position on Saturdays, would SC please inform all staff of this change. The following weekend (February 7th, 2009) neither RN on duty (LR and S©C) had been informed of this change by SC. The Manager, SC, had informed PCT, R(E)F, of the change in her assignment on Saturdays to provide care to all patients on the Unit. On February 7th, 2009, PCT, R(E)F, informed the RN's on duty of SC' s instructions as to how the assignments were to be made. PCT, R(E)F, stated to LS that when SC told her of the staff assignment changes SC stated to her "the reason for the change was due to Linda Stillwell's complaint".

6. DATE: February 4th, 2009: Singled LS out as the sole reason patient's Mother was upset.

INDIVIDUAL/S TO WHOM DISCUSSED CONCERN: SC, Manager

INSTANCE: SC stated to LS that "the Mother of your patient told me you were "abrupt and dismissive in your behavior towards her". LS was rounding on patients and at 07:45 AM, LS was with patient and his Mother in Room 425. The patient had had an Appendectomy. The patient, age 17, was withdrawn and overtly sad. The patient's Mother expressed to me her frustration at the length of time (over six hours) her son had waited in the ED (Emergency

Department) while in pain. The Mother stated that "I have had no sleep. My son just returned to his room just after 01:30AM". The Mother's frustration and anxiety increased when after her son had been assisted up to the bathroom, on return to bed, he had an emesis (threw up) in the emesis basin and then when he blew his nose there was a scant amount of blood on the tissue. The emesis was gastric contents. While LS was flushing the emesis down the toilet in the patient's bathroom, the patient's Mother was talking and LS could not hear due to the noise of flushing the toilet. LS asked the Mother what had she said and the Mother appeared on the verge of tears. LS expressed to the Mother that the Doctor would be notified right away and a condition report given. LS tried to reassure the Mother that having an emesis after having received Anesthesia was not unusual and many times a person feels much better. The patient was examined and questioned as to any continued feeling of nausea. The Mother stated to LS that "I have no faith in my son's Doctor's attentiveness". LS' s partner, PCT,SL, entered the room and remained with Mother as LS went to Nurse's Station and paged the patient's Surgeon. PCT, SL, after listening to Mother's frustration with the Medical Management of her son, went to SC, Manager, and asked her to provide support. LS felt feeling of relief that the Mother was receiving counseling and a means to express their feelings further. After spending time with the patient and his Mother, SC spoke to LS in a critical manner, stating "you should have provided more support for this family", "this young man is facing a huge disappointment due to the fact he is now unable to participate in the Wrestling Tournament this coming Saturday and he was expected to be the State Champion".

OUTCOME: SC assigned this young patient to LS for the following two days that he was hospitalized, right up to and including, his Discharge Instructions. The patient's Mother expressed no further concern in regards to LS and ,in fact, both the patient and the patient's Mother expressed their appreciation and thanks for LS' s care and interventions. Then five months later, June 10th, 2009, the event where this patient's Mother was so overwrought with worry and lack of sleep, was written up in the STEP III Discipline issued by SC to LS. This STEP III Discipline, the most severe of Disciplines, was given without any prior Progressive Disciplines (neither a STEP I or a STEP II). Progressive Discipline is what is agreed upon between the Union, WSNA and MHS and is put forth in the Contact that was current for 2008 and 2009. In the Discipline it is written, LS has not "CHANGED YOUR BEHAVIORS AND

NURSING PRACTICE". Yet there were no subsequent complaints and no nursing practice errors.

7. DATE: February 5th, 2009; Singled Out LS to report to Manager each shift prior to 12 noon and give discharge status report on LS' s assigned patients.

INDIVIDUAL/S TO WHOM CONCERN DISCUSSED: SC, TL

INSTANCE: SC gave LS directive to report directly to her the discharge status of the patients assigned to LS and to do so daily and ongoing. This SC wrote was " due to the expectation that missed lunches and end of shift overtime for LS would be reduced and that to ensure "that patients are receiving safe and quality care". No other RN on the Unit had this expectation placed on them even though majority of staff had overtime and missed breaks and lunches and other Nurses and staff had patients express complaints concerning their treatment. As record, pertaining to the issue of missed breaks (without receiving reimbursement) and missed lunches (without reimbursement), MHS was being investigated by Washington State's Department of Labor during 2008 and 2009, and as of October, 2010, a lawsuit was filed by the Nurse's Union, WSNA, against MHS for violation of Fair Labor Laws.

8. DATE: February 6th, 2009 Singled out LS by SC, with TL support ,for LS' s one and only omitted medication and narcotic entry in Epic for one patient by issuing a STEP III Discipline (no Progressive Discipline, no STEP 1 or II, no medication error).

INDIVIDUAL/S WITH WHOM CONCERN DISCUSSED: SC AND TL

INSTANCE: LS' s omission of documenting the medications "given as ordered" to the patient in Room 428 occurred on January 30th, 2009, less that 30 days of the completion of the orientation to the new electronic chart called Epic. LS had one year experience in the electronic documentation of medications administered ( known as Emar). Documentation can be challenging on a daily basis, and LS' s record of successful documentation in the Emar for her multitude of patients over a year period of time and working 32 hours per week reflects that LS maintained MSH Medication Administration Policy, and reflects that LS had , throughout 30 years employment with TGH, never had any Patient Safety Violations. LS reported to her

Management that on the day of the omission of the patient's medications in the Emar, LS was entering an array of information into the various screens in the Epic that pertained to the following: Nurse's Note, Wound Assessment and Treatment, Pain Level and Treatment, Home Instructions (patient teaching), Valuables Documentation. LS ,in addition to maintaining the 5 Rights of Medication Administration (the Right Patient, the Right Drug, the Right Dose, the Right Route, and the Right Time), was reviewing the Discharge paperwork with the patient and his wife. LS presented to Management that at the time of the omission of the correct medications to the patient, the acuity of the patients was high, LS was in Charge of nine patients and providing direct care to six patients with PCT partner and was providing orientation and instruction to her RN Co-Worker, RD, since it was the first Saturday shift RD had worked. LS instructed RD on how to close the Unit by 15:30PM and how to enter Charges and how to capture number of hours (Length of Stay). LS assisted with RD' interventions to ensure that the discharged patients and the transferred patients (to Extended Care Facility or In-House Bed) occurred in a Timely manner and thereby prevented Overtime. An additional factor on the Saturday shift, there is reduced staff no Unit Clerk (HUC) at the desk to answer phones and call lights, and no Housekeeping Staff available to assist with transfers and discharges due to the fact Housekeeping Staff always do their cleaning on Saturdays after all the patients are off the Unit. On Saturdays, at this period of time, there was no assigned Hospital Transporter, as there is during the week that could be utilized to assist. Concerning LS' s non-willful act of not entering the Medications administered in the patient's Emar, there was no medication error, the 5 Rights were followed, there was no harm to the patient, there was no potential harm to this patient (the patient was discharged to home one hour after receiving his prescribed medications thereby no RN followed LS, thereby, no possibility of giving additional doses). LS did no gross negligence or willful misconduct.

OUTCOME: SC and TL issued a STEP III Discipline without giving any progressive discipline prior. LS had no prior omission of narcotic administration. LS asked her Managers, "DO ALL Nurses receive a STEP III Discipline with a first omission and when there was no harm to the patient?" LS asked her Managers, "Has every Nurse who has failed to follow MHS Medication Administration Policy been given a STEP III Discipline?" LS reported to her

Managers that the patient's wife was witness to the patient receiving his prescribed medications and that LS opened each medication in front to the patient and his wife and identified each individual medication as it was administered. LS restated that there was no medication error and the 5 Rights of medication administration were followed. LS reported that in the patient's chart and per the patient's testimony it is documented that none of the prescribed medications were new to the patient. This patient had a ten year history of chronic pain due to a MVA (Motor Vehicle Accident). The procedure performed on 1/29/2009 was a Spinal Cord Stimulator insertion to treat chronic pain for pain relief that has a poor response to narcotics. This patient had documented high narcotic tolerance and at time of his discharge, the patient had stable Vital Signs and his neurological status was at his baseline. The patient had been assessed by his Physician and had a written order for discharge to home. LS requested that the chart be reviewed to prove LS' s testimony that the medication was given at 09:20AM (documented in the Pyxis record ) and was discharged to home at 10:35AM (documented in the Epic record).

ADDITIONAL OUTCOME: During the August, 2009 Performance Evaluation that SC gave to LS, SC stated to LS that the reason the most severe Discipline was given to LS on February 6th. 2009, was not that LS had omitted the entry in the patient's Emar, it was that patient went home too soon after he had received the medications. SC informed LS that LS should have made the patient agree to remain in the Hospital for observation before giving the medications. THERE IS NO HOSPITAL POLICY THAT STATES THAT PATIENTS WHO ARE GIVEN THEIR PRESCRIBED MEDICATIONS AND ARE MEDICALLY STABLE AND HAVE A WRITTEN DISCHARGE TO HOME HAVE TO MEET A CRITERIA OF "WAITING TIME" AFTER ADMINISTRATION OF MEDICATIONS. LS inquired ,"What if this directive made the patient and his family angry?" SC stated to LS it would be their choice to write a letter of complaint and that would be OK and all LS would need to do was state in the Nurse's Note (in Epic) that the reason his discharge was delayed was for his wellbeing. LS inquired as to how long patient would be asked to stay after receiving his prescribed medications (again there is no "Wait Time Policy") and SC informed LS, one hour. LS asked SC TO REVIEW PATIENT'S CHART.



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Even though LS is well acquainted to receiving thank you's from the hundreds of patients she has provided care for over 33 years, this patient and his wife's comments of praise were such that LS was actually distracted with an overwhelming feeling of emotion. This strong emotional response that LS experienced ,she believed was due to the intensity of the new Epic system and how that was impounding herself and all RN staff and due to the critical and bullying manner both SC and TL were manifesting towards her after LS had brought the concerns of increased patient acuity on the Unit, lack of breaks and missed lunches and concerns for patient safety and increased likelihood of errors. This patient and his wife expressed to LS their appreciation "for the excellent care he had received". They stated to LS, "We have been in so many Hospitals and this is the best experience we have ever had". LS had stated to them in reply, "I think a great deal of the credit goes to RN, DD, who worked with you the last 16 hours ( DD was on a mandatory Double Shift due to the fact there was no 11-7 shift RN coverage). The patient, with his wife's agreement, stated to LS, "It is you and your expert care that has met all the expectations we have always felt should be met." The STEP III Discipline was not changed. No other RN received STEP III Discipline even though LS was aware of other RN's that omitted in the Emar medications they administered and the documentation of all the RN's omissions were captured due to the audit conducted by SC and presented to the WSNA Union's Nurse Representative, HW. In TGH' s Administrations response to the Grievance Discipline Without Just Cause LS filed February10th,2009, SM stated in writing, "LS had several meetings with SC reviewing LS' s lack of using the 5 Rights of Medication Administration in November, 2008 and SC had more meetings with LS in December,2008 in regards to Medication administration and that LS continued to miss vital documentation." This is SIMPLY NOT TRUE. There were not any omissions in documentation of narcotics prior to January 30th, 2009.Truly, where was patient safety compromised for THIS patient who received the Right medications, the Right doses, the Right route and the Right time and the Right patient and who remained in the Hospital one hour after receiving his prescribed medications and who had been assessed and discharged to home by his Physician and patient was discharged with stable Vital Signs and baseline Neurological status intact and was exceedingly happy with his Hospital stay at TGH?



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9. DATE: February 6th, 2009 SC Singled Out LS by stating to her Co-Workers at the Nurse's Station, "LS' s working is not an option."

INDIVIDUAL/S WITH WHOM CONCERN DISCUSSED: Per R(E)F testimony: SC, all 7-3 staff and all 3-11 staff

INSTANCE: On February 6th, 2009 3-11 shift needed RN coverage due to ill call. SC asked all RN 7-3 staff if anyone would work a Double shift to provide coverage for the needed 3-11 shift. All declined. Staff put forth LS' s name, due to the fact that on multiple occasions LS would willingly cover staffing needs of TGII and her Unit. SC announced at the Nurse's Station, "LS 's working is NOT AN OPTION."

OUTCOME: There were a multitude of times following February 6th, 2009, when both SC and TL REQUESTED and had LS WORK Management requested Overtime (especially, requesting LS to come in to Duty at 03:00AM instead of her usual scheduled 07:00AM start time). It is fact that DC, CEO of MHS, personally witnessed and gave thanks to LS for coming on Duty at 03:00AM on an occasion in May.2009 when there was an emergency on the Ambulatory Care Unit.

10. DATE: February 13th,2009 Singled Out LS to report to SC (each shift worked) prior to 12Noon and give discharge status report on LS' s assigned patients.

INDIVIDUAL/S TO WHOM CONCERN DISCUSSED: SC

INSTANCE: SC again spoke to LS of her directive to report to her daily by 12 Noon. LS was compliant with this directive and paged SC whenever SC and TL were not physically on the Unit .

OUTCOME: Overtime and missed breaks and lunches continued for majority of staff, yet LS was the only staff member to receive this directive.



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11. DATE: February 25th, 2009, Singled Out LS to be called off 15 minute break

INDIVIDUAL/S CONCERNS DISCUSSED WITH: SC

INSTANCE: LS reported off to Charge Nurse, CJ, and went to break room for 15 minute break. SC sent HUC to the break room with the directive to return to Unit now per Manager's directive. LS returned to Unit (with cottage cheese present in LS' s teeth) and was told that the question the Physician had had been answered by RN, LR. LS went into SC' s office and stated," I had reported off to the Charge Nurse and was on break, ,so why was my 15 minute break interrupted?" SC responded, "Your 15 minute break can always be interrupted, it is your 30 minute lunch that you can take undisturbed."

OUTCOME: LS inquired of the RN staff (LR, S©C, CJ, RD and FL) if SC, Manager or TL, Director, pulls them off their 15 minute breaks and all stated that when they were able to take their breaks, they enjoy their breaks uninterrupted. Fifteen minute breaks are not to be interrupted per Union, WSNA, and Labor agreement.

12. DATE: March 17th, 2009: Singled out LS as not making correct Staffing decision when in Charge position on Saturday, March 14th, 2009.

INDIVIDUAL/S TO WHOM CONCERN DISCUSSED: SC

INSTANCE: SC called LS into her office on March 17th,2009 and told LS, "You did not cut staff on Saturday, March 14th, 2009 when you kept 2 RNs and 1 PCT on duty." LS responded that the patients present on the Unit had high acuity needs and that the majority of them needed transfer to In-House beds as opposed to discharges to home. Transfers can require 2 staff members and 1 RN must remain on the Unit at all times. LS acknowledged that there was a Student Nurse in the Preceptor role and that a Student Nurse is never to be considered as Staff when making assignments.



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OUTCOME: SC restated to LS, "You should not be in the Charge position if you allow overstaffing. You should have cut the PCT. Your incorrect staffing cost this Unit too much." Of fact, LS keep note of staffing decisions by the other RN staff when they were in Charge position on Saturdays and the patient census on the Unit was at 7 patients. In all cases, staffing was kept at 2 RNs and 1 PCT. In particular, LS noted that on July 11th, 2009, there were 7 patients on the Unit and staff was kept at 2 RNs and I PCT by the Charge RN and the PCT on that Saturday was on Overtime having worked the 8 hours prior on 11-7 shift. LS reviewed with RN Co-workers (LR, RD) who did Charge position on Saturdays if they received criticism for the staffing decisions on Saturdays and no one had received criticism or negative input from SC, Manager or TL, Director.

13. DATE: April 22, 2009 , Singled out LS by SC to "immediately receive report from PACU (Post Anesthesia Care Unit).

INDIVIDUAL/S CONCEN DISCUSSED WITH: SC

INSTANCE: At 12:30PM on April 22nd, 2009, LS received seventh patient. At 14:30PM, LS was in discussion with EG, Physician Assistant, concerning a problem with her patient and the need for clarification of an order, when SC, Manager, stated to LS, "You need to take report NOW from PACU. LS looked at phone and there was no call on hold. The phone rang at that time and SC answered and put the call on hold and stated again to LS in a critical manner, "Take this call NOW." LS picked up the phone and the RN on the line stated to her, "I was put on hold so fast I did not get a chance to say that I actually need to speak to the HUC to check on a room assignment." LS responded to the RN, "Please, get the RN who can give me report on the patient that is to come out to room 421." (421 was not cleaned as yet and would require at least 20 minutes before patient could be received ). At 14:50PM, SC sent RN working the Short Stay side home Low-Census. SC directed LS to receive a transfer patient in room 420. This patient presented with an empty PCA (Patient Controlled Anesthesia) narcotic pump and in addition to LS assessing and teaching this patient, the patient needed a cervical collar to be obtained and fitted. LS then received the patient from PACU in room 421. After moving the patient from the



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gurney into his bed, LS provided him with care, assessment and teaching and completed the required documentation.

OUTCOME: SC treated LS in a critical and disrespectful manner and directives resulted in LS being late in giving Shift Report to the oncoming staff and put LS in overtime for which LS was again criticized for having overtime and costing the Unit too much.

14. DATE: April 28th, 2009 Singled out LS for not making assignment correctly.

INDIVIDUAL/S WITH WHOM CONCERN DISCUSSED: SC

INSTANCE: There were 8 patients on the Unit with 2 RNs and 1 PCT. The assignment was made based on the directive SC had given LS that when there was 1 PCT staff, the PCT was assigned all patients for care and the patients were divided between the two RN staff members. SC arrived on the Unit at 08:00AM after this assignment was in place. SC announced that LS had made the assignment wrong. SC stated that "My directive for no RN to be assigned Primary Care only applies on Saturdays." SC then changed the assignment and placed 1 RN on primary care for 2 patients and assigned LS six patients with the 1 PCT.

OUTCOME: Again, LS was treated in a critical manner and made LS feel singled out for "making the wrong decision" in front of her Peers even though LS was following the Directive that SC had given to her and SC had not at any time clarified that her Directive only applied to staffing on Saturdays.

15. DATE: May 8th, 2009 Singled out LS for mandatory Weekend change and removal from Charge Position even though LS had Seniority.

INDIVIDUAL/S WITH WHOM CONCERN DISCUSSED: SC



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INSTANCE: LS was informed by SC, Manager, that LS' s schedule was being changed permanently to the opposite weekend starting with the next Schedule. LS was informed that LS would not be in Charge position even though LS had Seniority.

OUTCOME: When a change in weekend schedule occurs due to Management's directive and this results in the RN working two consecutive Saturdays in a row, the RN receives Consecutive Weekend pay as stipulated in the contract between the Union, WSNA and TGH. On June 4th, 2009, SC told LS that SC could schedule LS off Saturday, June 13th, 2009 (thus preventing the need to pay LS Consecutive Weekend pay). LS responded to this offer by letting Manager, SC. know that LS needed to work her scheduled FTE.

OUTCOME: On June 10th, 2009, SC issued a STEP III Discipline to LS based on a Student Nurse complaint that SC had requested of the student to put in writing. This complaint was lodged May 6th, 2009. Thirty four days had passed since the student complained that she had had a poor learning experience while assigned with LS. No prior Progressive Discipline of a STEP 1 or a STEP 11 had ever been issued to LS concerning any previous issues with effective teaching. LS was given the most severe level of discipline with a three day suspension without pay. SC, by issuing this suspension to LS on June 10th, 2009, took LS off the schedule that had LS scheduled to work two Saturday shifts in a row per Management's decision and not due to LS' s request and thereby eliminated the Consecutive Weekend pay LS would have received for working her scheduled shifts.

16. DATE: June 10th, 2009 Singled out LS as being non-therapeutic concerning requesting family member to allow staff to "Return the patient" on arrival from PACU.

INDIVIDUAL/S WITH WHOM CONCERN DISCUSSED: SC, manager, NO, Manager

INSTANCE: AT 14:30PM, LS had received report from PACU on patient coming to Room 425. LS was asked by a family member, of the patient coming to Room 425, as to when the patient would arrive. LS gave the family member a condition report of "PACU reports he has

done well coming out of Anesthesia and that her loved one was just now being transported and would be arriving within approximately 10 minutes". LS informed the family member that on the patient's arrival, staff would transfer him into the bed and would be assessing his condition and needs and that it was best to remain outside the room or at the comfortable chairs in the Waiting Room at the end of the hall. The family member replied that she would remain outside the room. LS was friendly and positive in her interaction and expressed gratitude to her for understanding and obtained a large comfortable chair from out of the patient's room for the family member's comfort as she waited and allowed the staff to provide the best care to the patient.

OUTCOME: SC brought LS into her office at 15:30PM and stated to LS, "This is an example of you being non-therapeutic, I overheard you tell your patient's family member to wait outside the room so that you could assess your patient on arrival out of PACU." SC went on to say, "We are a patient/family focused Hospital and our staff are responsible to ensure this happens." LS responded, "What about HIPAA regulations that staff are to obtain permission from the patient as to who they want to know their private information?", and LS asked "What about limiting number of people in the room for safety reasons for the post-operative patients who can be at greater risk?" ( Swine Flu precautions) LS presented that it is her 30 practice and the ongoing practice of all staff on the Ambulatory Care Unit that family and friends are asked to remain outside of room when staff is 'Returning or receiving a patient', and that LS had not been told verbally or by Email of any new Policy that addresses change in established practice. SC responded, "I have NOT (told any staff members of this change in practice) but I will certainly remind everyone of the expectations at our next staff meeting." During the time period June 10th,2009 up until LS was Terminated Without Just Cause on December 1st, 2009, SC had not told any other staff members that they could not continue their practice of requesting family and friends of returning patients to remain outside of patient's room so that staff could assist their loved one. In fact, per PCT, RF 's testimony , during the time period December 1st, 2009 to present day, no staff has been criticized or been told of this expectation that she has ever observed or been told of; "only you Linda."



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17.DATE: June 10th, 2009. Singled out LS with STEP III Discipline for Failure to create a positive learning environment based on one Student Nurse's alleged depiction of events and with no Progressive Discipline (no prior issue with PROVIDING INSTRUCTIONS AND CLINICAL EXPERIENCE to students during the 8 months SC had been LS' s Manager and over the 30 years LS employed by TGH.

INDIVIDUAL/S WITH WHOM CONCERNS DISCUSSED: SC, MANAGER, NO, Manager of PACU

INSTANCE: On May 6th,2009, LS was assigned to precept Student Nurse, CC. LS was not introduced to the student by the Instructor, nor was LS informed by the student's Instructor what clinical skills the student was instructed to obtain. The Student Nurse, CC, went with me after Shift Report on my initial Patient Rounds. Following that, CC, was engaged with visiting with my patient in Room 424 (CC shared with this patient that prior to going back to school, she worked for a jeweler and had received recognition for being a "top seller"). LS heard this conversation while LS was entering documentation in the Epic chart as LS stood in the hall outside of Room 424. The Student Nurse came out of 424 and informed LS that she needed to call and find out her Password so that she could work in Epic. The student also stated she had "some assignments to do" in the computer. In addition to the time the student spent on the computer, the student left the Unit on three occasions for extended periods of time and then was back on Unit at 13:00PM. It was at this time that LS actively engaged with the Student Nurse and asked her if she would like to administer an IV (INTERVENOUS) Medication and she replied, "Yes". In LS' s thirty three year Nursing career, LS has taught a multitude of Student Nurses, New Hires, Returning-to-work hires and Agency Nurses. Based on this knowledge and experience, LS assessed that the Student Nurse did not seem to have an understanding of what the clinical experience consisted of ("Hands- On" patient care) and how the clinical experience can be of great benefit to the student to gain confidence and knowledge. After the IV Medication, Ancef, was noted on the patient's Emar in the Unit's computer in the Medication Room, the time and route were noted and the dose. The Medication was removed from the Pyxis and Student Nurse, CC, with LS' s instruction ,mixed the Medication in a 50cc bag of Normal Saline and labeled the bag with the patient's name, Room number, date and time and the name

and dose of the Medication. Once in the patient's room, after identifying the patient, LS perceived that the student was hesitant to learn how to assess a Saline Lock and how to prime the tubing and set the IV Pump. LS asked CC if she would feel more comfortable with her Instructor. For LS personally, when she was a Student Nurse (3 years clinical experience at TGH during her Nursing Education),always felt most comfortable with her Instructors and that was how LS learned most effectively. Through LS' s own Student Nurse experience and through communications with other Nurse's and their relaying their own experiences, Student Nurses can and do have many doubts, fears and accusations concerning the RN as a result of participating in their clinical experience in an Acute Care Hospital setting. LS found it disheartening that CC, Student Nurse interpreted my interactions with her in a negative way and that CC expressed that she did not benefit from her learning experience. LS did try to do her best to allay CC' s overt display of anxiety. The 5 Rights of Medication were adhered to as they are each and every time LS is involved in the administration of Medications and this is evident that in 33 years of Nursing, LS has never had a medication error (refer to LS' s employee Personal File). LS believes that the experience the Student Nurse, CC, had is something that the student needs to take some responsibility for, as well as, LS. LS spent time with her patient following the event of the Student Nurse being disengaged and anxious during her interactions with LS while in the patient's room. LS expressed to her patient that she was sad that the Student did not engage well with LS and the experience of 'hanging an IV piggyback". LS expressed, also, that "I wish I could have allayed her fears so that could have felt more confident in the clinical setting." My patient expressed to me, "I feel sorry for the Student Nurse, but I saw you did your best to help her." LS believes that she did fail CC when she did not request a meeting with the student's Clinical Instructor so that a better outcome could have occurred. LS was dealing with several stressors; timely documentations, a request for pain medication for one of my other assigned patients, a request for me to call PACU and to obtain report (SC had practice of openly criticizing LS if LS did not get report before PACU called a second time). LS was bewildered as to why Student Nurse, CC, manifested little investment in her clinical experience throughout the entire shift.

OUTCOME: On June 10th, 2009, thirty four days after the Student Nurse presented her allegations, SC issued a STEP III Discipline without any prior STEP I or STEP II for Failure to create a positive learning environment. In this Discipline, SC referenced back to January 21st, 2009 where LS was accused of being the sole cause of the patient's wife being upset due to LS asking her to allow her husband to be assessed on arrival from PACU ( of note, the PCT, R(E)F also asked the patient's wife to allow staff to work with her husband) and SC referenced back to February 4th, 2009, where LS was accused by SC of being the reason a young patient's Mother was upset when her son had an emesis (threw up ) and had a scant showing of blood on his tissue after he blew his nose and the patient's Mother stated, "I am exhausted. We had to wait over 6 hours in the ED and my son just got to his room this AM and she stated, "I have no faith in my son's Doctor's attentiveness". LS filed Grievance Without Just Cause on June 11th, 2009 and never got to go through any of the steps of the Grievance Process before being Terminated from her thirty one year employment with TGH on December 1st, 2009.

18. DATE: July 1st, 2009 Singled out LS when SC stated," Go apologize to the patient you just transferred to Room 401 on 4J I".

INDIVIDUAL/S TO WHOM CONCERN DISCUSSED: SC, Manager, PH, Nurse Educator

INSTANCE: LS' s patient was assessed by LS at 1300PM to have a heart rate between 140-150 beats per minute sustained. LS notified the patient's Physician and obtained order to move patient to a Telemetry bed on 4J I to be converted. LS tried twice to phone report to receiving RN. Both RN' s had been interrupted. LS went to the patient's room to give RN, CP, report on patient's AM medications and family notification. The Nurse Educator, PH, was in the patient's room actively documenting in Epic. CP was called to the Nurse's Station to take a phone call. LS had Discharge Papers WITH HER for the patient in room 429 who was waiting for his instructions so he could proceed home. LS stated to CP that LS would assist a patient and then return. After helping 429, LS went to the Nurse's Station on the Ambulatory Care Unit to let the HUC know that the patient's room could be cleaned and thereby helping have room prepared as

soon as possible to receive a patient from PACU. (of note LS had only 5 minute break all shift to go the bathroom and drink cup of water). SC stated to LS, "You need to go apologize to the patient you just transferred." SC stated to LS, "the patient said you made her feel that she wasn't important." SC HAD NOT SPOKEN TO THIS PATIENT. LS went immediately to the patient in Room 401 and stated to her, "I did not mean to cause you any anxiety when I said I was going to go assist another patient". The patient stated to LS that she was not aware of any problem and that she was thankful for my helping her and that she was feeling much better but had missed lunch and could I arrange for her to have food?"

OUTCOME: Patient 's well-being and optimal health was provided for by LS' s interventions and patient felt well and grateful to LS and hungry.

LS believed that Nurse Educator, PH, had phoned SC and made this accusation as to the patient feeling LS had made her feel unimportant. WHY would PH be compelled to make this kind of statement to SC? LS again felt singled out and bullied and treated in a disparate manner by SC.

19. DATE: July 14th, 2009 Singled out LS by criticizing LS' s intervention for her patient's pain relief.

INDIVIDUAL/S TO WHOM CONCERN DISCUSSED: SC, AN, GRIEVANCE OFFICER FOR WSNA UNION

INSTANCE: SC stated to LS that SC felt that LS had not intervened with pain medication quickly for the patient in Room 426 who needed additional pain medication intervention. LS reviewed the events as they occurred: Between 07:30 and 08:00AM, LS was doing first rounds and had medicated two of her assigned patients, when her partner told her that their patient in Room 426 had requested pain medication at 07:30AM and had not received it. LS had not been paged (of note LS wears a Tracker at all times and the Tracker was in good working order) or informed of this patient's request until the current time of 08:00AM. LS obtained the ordered pain medication, oral Percocet tabs two (of note it was just the correct amount of time when oral